

# AIDSMARK

## REGIONAL LESSONS LEARNED

### West and Central Africa

In West and Central Africa, poverty, ethnic diversity and political instability combine in countries that consistently rank among the least developed in the world (1). Sixty percent of the West African population struggles to survive on less than a dollar a day (2). The region is also home to remarkably diverse peoples, with more than 100 distinct languages spoken in Cameroon and the Democratic Republic of Congo (DRC), and a staggering 521 distinct languages spoken in Nigeria (3). Political strife has long ravaged West and Central Africa. The Rwandan genocide in 1994 destabilized the region, and the DRC's civil war has been one of the deadliest and most damaging in the world (4). Nigeria has experienced more military than civilian transfers of power since independence, while Côte d'Ivoire, long the economic powerhouse of West Africa, has recently been racked by civil war and instability.

AIDSMark responded with funding and technical assistance to HIV epidemics in nine West and Central African countries: **Benin, Burundi, Cameroon, Côte d'Ivoire, DRC, Guinea, Nigeria, Rwanda and Togo**.<sup>a</sup> Adult HIV prevalence in these countries ranges from 1.5 percent in Guinea (5) to 5.4 percent in Cameroon (6) and is largely concentrated among high-risk groups such as commercial sex workers (CSW), long-distance truck drivers and members of the armed forces. While these rates are low relative to those in Southern Africa, highly diverse populations, poor communication and transportation infrastructure, and civil unrest pose unique obstacles to HIV prevention programs in West and Central Africa.

### Lessons Learned

#### Despite disruption of distribution systems during protracted conflict, it is possible to maintain presence in a country and rebuild programs once conflict dies down.

With AIDSMark support, Population Services International (PSI) maintained programs in Burundi, Côte d'Ivoire, DRC and Rwanda through periods of extended internal conflict. The most compelling example comes from DRC, which was racked by intense political violence and instability during the 1990s. Though largely confined to Kinshasa, PSI affiliate *Association de Santé Familiale* (ASF) was one of few international non-governmental organizations (NGOs) that managed to maintain a presence in DRC throughout this period. This remarkable feat was accomplished thanks to a small, highly dedicated staff and the assistance of national partners. Initially, ASF/DRC managed to self-finance activities (including staff salaries) through the sale of condom stocks left behind by the U.S. Agency for International Development (USAID). When the security situation began to improve in the late 1990s, AIDSMark stepped in to lead the field in condom social marketing and HIV prevention programs in DRC. With this support, ASF/DRC began to rebuild sales networks and ensure consistent product supply. Although hostilities officially ceased in 2003, insecurities continue to this day. Nonetheless, ASF/DRC has rebuilt distribution networks, increased storage capacity and partnered with the national AIDS coordinating body, the *Programme National de Lutte Contre le SIDA*, to expand distribution. These efforts, along with promotional campaigns and significant latent demand, caused ASF/DRC's condom sales outside Kinshasa to grow from 15 percent of its total sales in 2001 to more than 47 percent of total sales in 2006 (7).

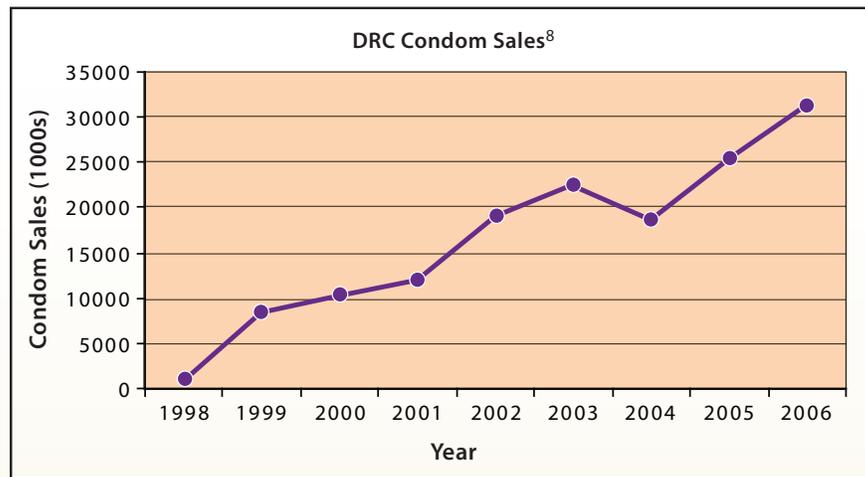


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<sup>a</sup> As Francophone countries, Rwanda, DRC and Burundi are programmatically included in the West and Central Africa region.



**In insecure environments, even small-scale investments can help country programs demonstrate viability, build donor confidence and attract follow-on funding from diverse sources.**

AIDSMARK provided seed money to launch HIV prevention programs on a small scale in several West and Central African countries experiencing civil and political strife. These initiatives laid the groundwork for attracting follow-on funding for larger, more comprehensive programs from diverse sources. In 1998, AIDSMARK funded PSI/Togo to

strengthen sustainable condom social marketing and conduct HIV prevention activities with migrant populations. With this support, PSI/Togo built its capacity to such a degree that when AIDSMARK funding ended in 2000, it became the prime recipient of HIV prevention funds in the country under Round Four of the Global Fund (9). In Burundi, PSI maintained operations through periods of political instability, civil war and funding cuts. When expatriate staff members were forced to evacuate in 1996, PSI/Burundi continued working through its local affiliate, *Population, Santé et Information*. During this period, only the Department for International Development (DfID), the United Nations Population Fund and the World Bank joined AIDSMARK in funding PSI/Burundi's work. When expatriate staff returned to Bujumbura in 2002, continued AIDSMARK support allowed the social marketing program, which included interventions targeting vulnerable groups such as CSWs and internally displaced persons, to expand (10). Thanks to the success of these programs, PSI/Burundi managed to double its funding for condom social marketing by competing for awards from the Dutch, German and British governments, as well as from the United Nations Children's Fund (UNICEF), Pfizer and Action Aid. In DRC, AIDSMARK invested \$12 million in a large-scale HIV prevention and capacity-building program between 1998 and 2005. The program demonstrated that large-scale projects could be successfully implemented in this challenging environment. As a result, ASF/DRC received large follow-on grants from the Global Fund, USAID and DfID (11).



**While mass media continues to be an important awareness-raising channel of communication, interpersonal communication (IPC) is required to achieve greater behavioral impact.**

ASF/DRC used mass media and IPC to promote the *Prudence* condom brand, spread HIV awareness and prevention messages, and promote family planning. Since inception, the mass media component of the program has reached an estimated 10 million people and has built one of the only professional media production studios in the country (11). Mass media reach was limited, however, because of the multiplicity of languages spoken in DRC, lack of communication infrastructure and lack of electricity in many parts of the country. As a result, ASF/DRC complemented mass media with targeted IPC programs that reached an additional 700,000 (since 1998) of those most vulnerable to HIV, including CSWs, mobile populations such as transportation workers, members of uniformed services (military and police) and youth (11). Although the ability to measure the results of these activities was greatly limited by lengthy periods of instability through the life of the project, during the periods when evaluation was possible, significant results were found among the target groups: 70 percent increase in CSWs reporting condom use during last sex act with a paying partner, 75 percent increase in clients of CSWs reporting condom use during last sex act with a



paid partner, 57 percent increase in reported condom use by people in uniform during last sex act, 55 percent increase in CSWs and their clients who believe that their partner could be infected with HIV and 75 percent increase in CSWs who report feeling capable of convincing a client to use a condom (11).

Under AIDSMARK, Society for Family Health (SFH)/Nigeria launched an ambitious multichannel intervention called “Make we Talk” to promote HIV risk reduction by increasing knowledge and access to HIV prevention products, promoting abstinence and accurate risk perception for HIV and creating an enabling environment for HIV prevention programs. The program targeted high-risk groups

including CSWs and their clients, transport workers, members of uniformed services and youth between the ages of 15 and 24. The SFH/Nigeria approach was two-pronged, with both macro (federal-level advocacy, nationwide media coverage, nationwide product distribution) and micro (community-based interventions through national partner collaboration) approaches. On the macro scale, mass and mid-media campaigns were launched nationwide. An integral portion of the SFH/Nigeria strategy was the micro-level community-based initiative. Through SFH/Nigeria’s 16<sup>b</sup> regional offices, collaborations and sub-contractual relationships were formed with national NGOs, community-based organizations, civil society organizations, faith-based organizations and local health clinics. These collaborative arrangements permitted behavior change messages to be directly accessible to community members and target groups through intensive and participatory IPC methodologies such as mobile video/road shows for sex worker clientele. By the end of 2005, SFH/Nigeria contributed to significant increases in reported abstinence among male youth (from 63.6 percent in 2003 to 67.6 percent in 2005) and consistent condom use among CSWs (from 55.3 percent in 1999 to 80 percent in 2005) (12). Overall, the program found that participatory and repetitive IPC at the community level was the primary driver of behavior change (12).

### **HIV prevention programs can best reach military personnel by utilizing the existing organizational structure of the military.**

AIDSMARK support enabled PSI/Rwanda to expand HIV prevention initiatives within the brigades of the Rwandan Patriotic Army. Recognizing and harnessing key features of the military’s organizational structure, such as close living and work quarters, the program ensured successful diffusion of HIV prevention interventions. The program was designed to increase HIV risk perception, increase self-efficacy for HIV prevention behaviors and encourage soldiers to carry condoms and utilize HIV counseling and testing (CT) services. Events held within brigades, such as the “Strong Man Body Building Competition,” served to link images of strength with condom use and health. These messages were reinforced by repeat contacts with IPC programs delivered by trained military peer educators that tailored communications at an individual level. The reach of mass media was extended into military camps through the use of traveling cinémobiles that screened military-specific films and video spots. Soldiers deployed in neighboring countries were also targeted with deployment-specific messages as well as messages regarding condom use and partner reduction. PSI/Rwanda intensified efforts targeting military personnel with the introduction of mobile CT, which led to a surge in demand for CT services. Military personnel were again used in the delivery of the intervention, where they were trained as counselors and were given ongoing training and oversight to ensure delivery of high-quality CT services and continuous counseling after the CT outreach. HIV-positive soldiers on active duty were also enlisted to impart testimonials on living positively and to correct misconceptions about the virus. The program was successful in reaching soldiers: from April to June 2005, IPC sessions reached more than 9,800 soldiers, and demand for mobile CT increased so that additional staff were required to meet the demand (13, 14).

Amid ongoing hostilities in the late 1990s, ASF/DRC also used AIDSMARK funding to create an HIV prevention program targeting military



<sup>b</sup> At the time, SFH Nigeria had 16 regional offices. It now has 17 regional offices.

personnel. The program used peer educators to inform military personnel about HIV transmission and prevention and established condom sales points within military bases. The scale of the program remained limited because of continued armed conflict. However, collaborations formed during this time allowed scale-up of the program once hostilities eased and the army nationalized. In the last year of the program, behavior change communication sessions had reached more than 27,000 military officials (15). Eventually, ASF/DRC's military prevention model was adopted by the DRC's military as a standard for its own HIV prevention programming.

### Even highly successful national NGOs must continue to evolve and explore new dimensions of sustainability through organizational learning.

SFH/Nigeria, an independent NGO, was founded in 1985 by several prominent Nigerians and PSI. Starting with two employees and one office in Lagos, SFH/Nigeria has grown to more than 200 employees working out of 17 offices scattered across Africa's most populous country. SFH/Nigeria began with one product and one HIV prevention grant and now markets nine products and manages five contracts worth \$120 million. The organization's health impact has grown even more dramatically, as it currently prevents more HIV infections and unintended pregnancies than any PSI-affiliated program in the world (16). AIDSMARK consistently supported collaboration between SFH/Nigeria and PSI between 2000 and 2005. As a result, in 2005 SFH/Nigeria became the first Nigerian NGO certified to receive direct funding from USAID. Today, SFH/Nigeria continues to diversify its portfolio by expanding activities in the areas of malaria prevention and safe water, and by collaborating with other leading national and international organizations. Having made great strides in developing institutional and technical capacity under AIDSMARK, SFH/Nigeria was poised to explore new dimensions of sustainability. In 2006, following two years of negotiation with a private manufacturer, SFH/Nigeria became one of the first donor-supported national NGOs in the world to experiment with marketing commercially sustainable brands under the USAID-funded "Private Sector Partnerships-One" project (17). While it is still too early to evaluate the success of this initiative, it is evident that SFH/Nigeria will need to adapt its organizational structure and culture to integrate and manage commercial and noncommercial activities under one roof (17). For instance, it will need to adopt new cost accounting practices and internal incentive systems (17). Thus, even well-established and highly successful national NGOs must continue to evolve by exploring new dimensions of sustainability – a goal best attained by employing organizational learning to guide the growth and adaptation process.

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